STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 French Landing. Suite 300
Heritage Place Metro Center
Nashville, TN 37243

BOARD OF COMMUNICATION DISORDERS AND SCIENCES

(615) 532-3202 or 1-800-778-4123
www.tennessee.gov/health

APPLICATION INSTRUCTIONS FOR CERTIFICATION AS A SPEECH PATHOLOGIST OR AUDIOLOGIST LICENSURE APPLICATION CHECK SHEET

Provided below is a checklist for your personal use and convenience containing all the things you must submit before your application for Tennessee licensure to practice speech pathology/audiology can be considered. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will rejected by the Board.**

A criminal background check is required for all methods of licensure. For instructions to obtain a criminal background check, click here or go to the Noteworthy section of the Board's website.

METHOD OF LICENSURE

If applying by Certificate of Clinical Competence

The following documentation is required:

1. _____ Completed application.
2. _____ Fee One Hundred Sixty Dollars ($160)
3. _____ Transcript. Official transcript sent directly to the Board from graduate school (transcript issued to student is not acceptable).
4. _____ Official verification sent directly to the Board from ASHA verifying that your CCC has been awarded.
5. _____ Verification of licensure from each state(s) in which you hold or have held a license. (See Attached Form)
6. _____ Original, signed, and notarized passport photograph taken within the preceding twelve (12) months. (Passport photograph only)
7. _____ Letter of Recommendation (Moral Character)
8. _____ Mandatory Profile Questionnaire
9. _____ Certified photocopy of birth certificate
10. _____ Criminal Background Check

If applying by Reciprocity:

The following documentation is required:

1. _____ Completed application.
2. _____ Fee One Hundred Sixty Dollars ($160)
3. _____ Verification of licensure from each state in which you hold or have ever held a license. (See Attached Form)
4. _____ Official copy of licensure requirements from state(s) in which you are currently licensed.
5. _____ Original, signed, and notarized passport photograph taken within the preceding twelve (12) months. (Passport photograph only)
6. _____ Copy of your under-graduate and graduate transcripts.
7. _____ Copy of your degree.
8. _____ Mandatory Profile Questionnaire
9. _____ Certified photocopy of birth certificate
10. _____ Criminal Background Check

If applying by Criteria:

The following documentation is required:

1. _____ Completed application.
2. _____ Fee One Hundred Sixty Dollars ($160)
3. _____ Transcript. Official transcript sent directly to the Board from graduate school (transcript issued to student is not acceptable).
4. _____ Verification of successfully completed practicum of at least three hundred (300) clock hours.
5. _____ Verification of successful completion of nine (9) months full-time or eighteen (18) months half-time professional employment (CFY).
6. _____ Letter of recommendation from the Director of training program from which the academic training and practicum were obtained.
7. _____ Verification of a minimum score of six hundred (600) on the National Teacher Examination in Speech Pathology and Audiology sent directly to the Board from N.T.E.
8. _____ Mandatory Profile Questionnaire
9. _____ Certified photocopy of birth certificate
9. _____ Verification of licensure from each state(s) in which you hold or have held a licensure.
10. _____ Original, signed, and notarized passport photograph taken within the preceding twelve (12) months. (Passport photograph only).
11. _____ Letter of Recommendation (Moral Character)
12. _____ Criminal Background Check

UNDERSTANDING THE APPLICATION PROCESS

If an address change occurs <u>at any time, you must</u> notify the Board office, in writing, immediately.

1. All application fees are non-refundable.

2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

Board of Communication Disorders and Sciences 227 French Landing, Suite 300 Heritage Place Metro Center Nashville, TN 37243	**For Federal Express or Special Courier: Board of Communication Disorders and Sciences 227 French Landing, Suite 300 Heritage Place Metro Center Nashville, TN 37243**

3. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services <u>will not</u> appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used you <u>will</u> be responsible for charges incurred. The Board asks that you please give the Board office every consideration in this matter.

4. **We will discuss application status with the applicant, applicant's spouse, or to whom ever may hold power of attorney <u>only</u>.** Please inform hospitals, employers, recruiters, referral companies, or insurance companies that application status updates must be obtained from the applicant. Status information will be mailed to the address listed on the application.

5. If necessary documentation has not been received when your application has been received by the Board office, an initial deficiency letter will be sent to you by mail.

6. **Absent any complicating factors, <u>the average application processing time is six (6) weeks.</u> Once the application is completed, your file will be promptly reviewed and an initial certification determination made. You will be promptly notified by letter of the initial determination.**

7. It is recommended that you <u>do not</u> make arrangements to accept employment as a Speech Pathologist/Audiologist Practitioner in Tennessee unless you are ASHA certified or until you are granted a license by the Board of Communication Disorders and Sciences.

8. Applications that are deficient sixty (60) days after receipt of the initial deficiency letter will be closed.

Thank you for your cooperation. We will make every effort to expedite your application in an efficient manner.

IMPORTANT: You must have a Tennessee License from the Board in your possession before you may lawfully practice as either a Speech Pathologist or Audiologist.

ATTACH A CURRENT FULL-FACED PHOTOGRAPH (SIGNED AND NOTARIZED)

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TN 37243

Speech Pathologist
A. 2023 - 001 - $ 50
2023 - 006 - $ 10
2023 - 001 - $100
$160

Audiologist
B. 2024 - 001 - $ 50
2024 - 006 - $ 10
2024 - 001 - $100
$160

BOARD OF COMMUNICATION DISORDERS AND SCIENCES

LICENSURE ALTERNATIVES

[PLEASE TYPE OR PRINT LEGIBLY]

CHECK TYPE OF LICENSE DESIRED: __ Speech Pathology __ Audiology (check yes or no)
Dispense/sell hearing aids _ Y __ N

A. Speech Pathologist License

_____ Certificate of Clinical Competence
_____ Reciprocity
_____ Criteria

B. Audiologist

_____ Certificate of Clinical Competence
_____ Reciprocity
_____ Criteria

PERSONAL INFORMATION

PLEASE PRINT IN INK

Name: _____
Last First Middle Maiden

Social Security Number: _____-___-_____ Date of Birth:_____

Mailing Address:_____ County (TN Applicants Only): _____
_____
_____ Phone: Home: __(____)_____-_____
_____ Office: _(____)_____-_____

Email Address: _____

Place of Birth: _____ Sex: (optional - for statistical purposes only)
Female _____

U.S. Citizen: Yes _____No _____ Male _____

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond junior high or middle school. Use the back of this page if you need additional space.

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr Educational Institution Degree Awarded

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr Educational Institution Degree Awarded

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr Educational Institution Degree Awarded

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr Educational Institution Degree Awarded

Practicum (300 clock hours of supervised, direct clinical practice). Give dates and brief description.

_____

_____

_____

EMPLOYMENT STATUS

Are you currently employed? [ ] Yes [ ] No If yes, give name and address of primary

DATES		**LOCATION**		**POSITION AND DUTIES**
From: _____ To:	_____	_____		_____
Mo/Yr	Mo/Yr	(City)	(State)	_____
From: _____ To:	_____	_____		_____
Mo/Yr	Mo/Yr	(City)	(State)	_____
From: _____ To:	_____	_____		_____
Mo/Yr	Mo/Yr	(City)	(State)	_____

Do you have more than one (1) employer? [ ] Yes [ ] No

(If yes, list names, addresses, and job title)

NAME ADDRESS JOB TITLE

_____

_____

Do you engage in private practice? [ ] Yes [ ] No If yes, give location:

_____

_____

LICENSURE INFORMATION

List below **ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED PERMITTED OR CERTIFIED** as a Speech Pathologist/Audiologist. Additional pages may be added if necessary. Submit a copy of Licensure verification form to all such states, countries, or provinces regarding such licensure, certification, or permit. Use the back of this page if you need additional space.

STATE	LICENSE NUMBER	DATED ISSUED	CURRENT STATUS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List below **ALL** states, countries, or provinces in which you hold or have ever held a license, certification, or permit as a health professional other than a Speech Pathologist/Audiologist. Submit a copy of Licensure verification form to all such states, countries, or provinces regarding such licensure, certification, or permit. Use the back of this page if you need additional space.

STATE	LICENSE NUMBER	DATED ISSUED	CURRENT STATUS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative,** attach an explanation on a separate sheet. ***In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application.***

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:

   a. The cognitive capacity to make appropriate clinical diagnosis (if necessary), exercise reasoned judgments, to learn, and keep abreast of developments in your profession;

   b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devises, such as voice amplifiers; and

   c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. **"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

3. **"Chemical substances"** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS:

		Yes	No
1.	Do you currently have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?		
	a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?	____	____
	b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	____	____

[If you receive such ongoing treatment or participate in such a monitoring program, the Committee will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license or certificate should be issued, whether conditions should be imposed, or whether you are not eligible for licensure or certification.]

COMPETENCY INFORMATION CONTINUED

QUESTIONS:	**Yes**	**No**
2. Do you currently use chemical substances?	____	____
a. If yes, do they in any way impair or limit your ability to practice your profession with reasonable skill and safety?	____	____
3. Are you currently engaged in the illegal use of controlled substances?	____	____
a. If yes, are your currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	____	____
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	____	____
5. If you have ever held or applied for a license or certificate to practice Speech Pathology/Audiology in any state, country, or province, has it been or was it ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, voluntarily surrendered under threat of investigation, or disciplinary action?	____	____
6. If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited or otherwise disciplined, voluntarily surrendered under threat or restriction, or disciplinary action?	____	____
7. Have you ever failed a Speech Pathology/Audiology licensure examination?	____	____
8. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	____	____
9. Have you ever been rejected or censured by a professional society?	____	____
10. In relation to the performance of your professional services in any profession:	____	____
a. Have you ever had a final judgment rendered <u>against</u> you;	____	____
b. Have you ever had settlement of any legal action rendered <u>against</u> you; or	____	____
c. Are there any legal actions pending <u>against</u> you or to which you are a party?		
11. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, voluntarily surrendered under threat of investigation, or disciplinary action?	____	____

APPLICANT:FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, _____, of _____, being duly sworn and
(Applicant's Name) (City) (State)
identified as the person referred to in this application, attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the rules and regulations, which were enclosed in the application packet, and agree to abide by the them in the practice of Speech Pathology/Audiology in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice Speech Pathology/Audiology.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and other qualifications for certification.

ACKNOWLEDGE that I, as an applicant for certification, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE I hereby authorize release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

In order to comply with federal statutes, the (Board of Communications Disorders and Sciences) is obligated to inform each applicant or licensee from whom it requests a social security number that disclosing such number is mandatory in order for this Board to comply with the requirements of the federal Healthcare Integrity and Protection Data Bank and/or the National Practitioner Data Bank. If the Board is required to make a report about one of its applicants or licensee to either or both of these data banks, it must report that individual's social security number. This application will not be complete if the social security number is omitted. The number will be used for identification purposes and for such other purposes as are allowed by state and federal law.

_____ _____
SIGNATURE **DATE**

Sworn to before me this _____ day of _____, 20 _____.

_____
NOTARY PUBLIC Affix Seal Here

My Commission Expires _____

ATTACHMENT I

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TN 37243

BOARD OF COMMUNICATION DISORDERS AND SCIENCES

(615) 532-3202 or 1-(800)-778-4123
EDUCATION VERIFICATION

APPLICANT: Supply the information requested in this box and then mail this entire form to the school at which you completed your Speech Pathology/Audiology educational program. **NOTE:** Many schools require a fee, so you may wish to contact the institution before mailing this form so that you can attach their fee.

TO WHOM IT MAY CONCERN:

I am applying for a certificate or permit to Practice Speech Pathology/Audiology in the State of Tennessee. The Board of Communications Disorders and Sciences requires verification of educational attainment. Please forward an original transcript showing degree awarded and bearing the institution's official seal to the Board address below.

Applicant's Full Name _____
(Last) (First) (Middle/Maiden)

Applicant's Address:_____
_____
_____
_____

Applicant's Social Security Number: _____-_____-_____

Applicant's Student Identified Number:_____

Year of Graduation: _____

Degree Conferred: _____ Date Degree Conferred: _____

Please forward an original graduate transcript bearing the institution's official seal to:

BOARD OF COMMUNICATION DISORDERS AND SCIENCES
FIRST FLOOR, CORDELL HULL BUILDING
425 FIFTH AVENUE NORTH
NASHVILLE, TN 37247-1010

Thank you for your cooperation and prompt response.

_____ _____
Applicant's Signature Date

ATTACHMENT II

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE300
HERITAGE PLACE METRO CENTER
NASHVILLE, TN 37243

BOARD OF COMMUNICATION DISORDERS AND SCIENCES
(615) 532-3202 or 1-(800)-778-4123
VERIFICATION FROM OTHER STATE CERTIFICATION BOARDS

APPLICANT: Please provide the information requested in the top box and then mail one (1) form to the certification board in EACH state where you **hold or have ever held** a certificate/license/permit to practice any profession. (Copies of this form can be used). **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish the contact the applicable state(s).

To Be Completed By Applicant (Please Print In Ink)

I, the undersigned applicant, was granted a (**circle one)** license/certificate/permit to practice _____
(Profession)
with (**check one**) License □/Certificate □/Permit □ number _____ on _____
(Date)
in the State of _____. The Tennessee Board of Communication Disorders and Sciences requests that I submit evidence of the current status of that license in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Board of Communication Disorders and Sciences.

Date:_____ _____
Applicant's Signature

_____
Applicant typed or printed name

To Be Completed By Administrative Office of State Certification Board

Name In Full As It Appears On License/Certificate or Permit:

_____
(First) (M.I.) (Last)

License/Certificate/Permit Number: _____ Profession: _____

Date Issued:_____ Date of Expiration: _____

Basis of issuance
(Check One) ( ) CCC from ASHA ( ) Reciprocity
( ) Other, specify _____

The license is currently active and registered? _____ Yes _____ No

Is there any derogatory information on file? _____ Yes _____ No If yes, please attach supporting documentation

_____
Authorized Signature Title Date

PH 1275
Rev (02/04)

RDA/S 836-1

FEE SCHEDULE FOR THE BOARD OF COMMUNICATION DISORDERS AND SCIENCES
CHECK TYPE OF LICENSURE YOU ARE APPLYING FOR

SPEECH PATHOLOGY

SP □	**(Total fee due $160)**	
$50	APPLICATION FEE	23-001
$100	LICENSE FEE	23-001
$10	STATE REGULATORY FEE	23-006

AUDIOLOGY

AUDIO □	**(Total fee due $160)**	
$50	APPLICATION FEE	24-001
$100	LICENSE FEE	24-001
$10	STATE REGULATORY FEE	24-006

NAME OF APPLICANT: _____
(PLEASE PRINT)

*ATTACH CHECK OR MONEY ORDER PAYABLE TO THE **(BOARD OF COMMUNICATIONS DISORDERS AND SCIENCES, SPEECH PATHOLOGY OR AUDIOLOGY)**, TO THIS PAGE AND ATTACH THIS PAGE TO THE FRONT OF THE APPLICATION (PAGE), IF APPLYING AS A SPEECH PATHOLOGIST OR AUDIOLOGIST*

MH/JW/G5047072/CDS

TENNESSEE DEPARTMENT OF

HEALTH

MANDATORY

PRACTITIONER

PROFILE QUESTIONNAIRE

PURSUANT TO TENNESSEE CODE ANNOTATED SECTION 63-51-101 et seq, LAWS OF TENNESSEE

FOR

LICENSED HEALTH CARE PROVIDERS

FOREWORD

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. § 63-51-101 et seq, requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health. The information specified in the law is contained in the attached questionnaire. From the information submitted, the Department will compile a practitioner profile which is required to be made available to the public via the World Wide Web and toll-free telephone line after May 1, 1999. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information constitutes a ground for disciplinary action against your license. A blank copy of the profile may be obtained from the following web site address: http://tennessee.gov/health**.**

On the department's homepage, under Licensing, click on "Health Professional Boards"; then select the appropriate board.

TABLE OF CONTENTS

SECTION I: GENERAL INSTRUCTIONS

- **Read all instructions thoroughly before completing the profile questionnaire. Incomplete or omitted information may delay meeting the mandatory reporting requirement.**
- **Incomplete or illegible profiles will be returned to the provider for resubmission.**
- **Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **Provide only information for the previous ten (10) years where indicated on the questionnaire.**
- **Complete the questionnaire and attachments by typing or printing your response in block letters in ballpoint pen. Incomplete or illegible profiles will be returned to the provider for resubmission. Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **DO NOT RETURN THESE INSTRUCTIONS WITH THE QUESTIONNAIRE TO THE DEPARTMENT.**
- **You may have completed a similar questionnaire for another state's licensing board. If so, Tennessee law still requires you to complete and submit this form.**
- **If you have an active Tennessee license you are required to complete the questionnaire. This includes those practitioners who are retired or no longer practicing.**

- **Mail the completed ORIGINAL profile questionnaire <u>within thirty (30) days of its receipt by the provider</u> to:**

Healthcare Provider Information Manager
Tennessee Department of Health
Division of Health Related Boards
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243
1-800-778-4123
Local - (615) 532-3202

- **<u>Keep a copy of the questionnaire for your records.</u>**

✓CHECKLIST

Before you mail your questionnaire:

- ☐ Have all questionnaire and supplemental pages been completed with the name of the practitioner, profession and license number at the top of the page?

- ☐ Have supplemental pages been clearly labeled with the corresponding question for which the response is being provided?

- ☐ Have you retained a copy of your signed questionnaire?

SECTION II:

COMPLETING THE PROFILE QUESTIONNAIRE

QUESTIONNAIRE DEADLINE

The provider must submit the questionnaire on or before thirty (30) days from its receipt.

COMPLETING THE FORMS

Complete all forms by printing neatly in block letters in ballpoint pen or typing the information. If a question does not apply to you, indicate so by checking the "Does not apply" box. **Illegible questionnaires will be returned.**

The following numbered parts correspond to the matching number on the questionnaire form.

I. PRACTITIONER DATA

Complete part one (1) noting the following:

- License number: Fill in your license number and indicate your profession in the space provided.
- Social security number: **Your social security number will not be published or in any way given out to the public. It is required for in-house tracking purposes only.**
- Address: Complete mailing and practice address (if applicable). Retirees: Write in "N/A" for practice address.

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

List chronologically all medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a “yes” or “no” response. A brief statement in the space provided should follow a "yes" answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

V. STAFF PRIVILEGES

List all hospitals at which you hold staff privileges. This includes:

- Licensed hospitals-this term is defined at T.C.A. § 68-11-201.

In the spaces provided, answer information about the TennCare plans in which you participate, if any. If there are more than five (5), please send attachment.

VI. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal’s period expired, or that the applicable board issued an agreed order or consent decree.

In the “Description of Violation” spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, fraud, etc.

In the “Description of Action” spaces, indicate the type of disciplinary action imposed against your professional license.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer “yes” to any of the questions in this section and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of

disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions VII B and C in their entirety before answering those questions.

VII. CRIMINAL OFFENSES

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice of a profession within the most recent ten (10) years. If you answer "yes" to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

VIII. LIABILITY CLAIMS

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19,1998, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE THRESHOLD AMOUNT ESTABLISHED BY YOUR TENNESSEE LICENSING BOARD ARE NOT REQUIRED TO BE SUBMITTED. To find out the threshold amount established by your board, consult your board's web page at www.state.tn.us/health/ or call 1-800-778-4123. Pending malpractice claims are not required to be reported unless/until final adjudication against you.

IX. OPTIONAL INFORMATION

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required.

Practitioner's Name _____ **License #** _____
Profession _____

SECTION III:

HEALTHCARE PROVIDER INFORMATION MANAGER
TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243

I. PRACTITIONER DATA

A. PROFESSIONAL LICENSE NUMBER: _____ PROFESSION: _____

B. SOCIAL SECURITY NUMBER: _____ (**This will not be published as part of the profile or website).**

C. NAME (INCLUDE MAIDEN AND ON 2ND/3RD LINES ANY ALIASES, IF APPLICABLE):
CURRENT NAME:

_____
(LAST) (FIRST) (MIDDLE AND MAIDEN NAME) (IF APPLICABLE)

FORMER NAME(S):

_____
(LAST) (FIRST) (MIDDLE)

_____
(LAST) (FIRST) (MIDDLE)

D. MAILING ADDRESS:

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

PRIMARY PRACTICE ADDRESS: (This will be published as part of the profile and the web site).

_____
(PRACTICE NAME)

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

E. TELEPHONE:(_____)_____**(This will not be published as part of the profile or the web site).**

F. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English or translation services that may be available at your primary practice location.

1. _____
2. _____

G. SUPERVISING PHYSICIAN: If you are required by law to be supervised by a physician (physician assistant or nurse practitioner) indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets:

1. _____
2. _____

Practitioner's Name _____ **License #** _____
Profession _____

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))

PROGRAM/INSTITUTION	CITY/STATE/ COUNTRY	DATE OF GRADUATION	TYPE OF DEGREE
1.			
2.			
3.			
4.			
5.			
6.			

B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY,STATE, COUNTRY)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.			
2.			
3.			
4.			

Practitioner's Name _____ **License #** _____
Profession _____

III. SPECIALTY BOARD CERTIFICATIONS

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) (Authority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete section below. YES ❒ NO ❒

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1.	
2.	
3.	
4.	
5.	

IV. FACULTY APPOINTMENTS

A. Have you had the responsibility for graduate medical education within the last ten (10) years? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

If "YES", list the title of the appointment and name(s) and city/state of institution(s). (Attach additional sheets, clearly labeled with this question number, if necessary.)

	TITLE	INSTITUTION	CITY/STATE
1.			
2.			
3.			
4.			

V. STAFF PRIVILEGES

A. Do you currently hold staff privileges at a hospital? (Authority: T.C.A. §63-51-105(a)(a)) YES ❒ NO ❒

If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

	Name of Hospital	City/State
1.		
2.		
3.		
4.		
5.		

Practitioner's Name _____ **License #** _____
Profession _____

B. Do you currently participate in any TennCare plan? (Authority: T.C.A. § 63-51-105(a)(16)) YES ❒ NO ❒
If "YES", list each plan in which you currently participate:

Name of TennCare Plan
1.
2.
3.
4.
5.

VI. FINAL DISCIPLINARY ACTION (See Instructions)

A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

	AGENCY NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name_____ **License #**_____
Profession _____

B. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted for reasons related to competence or character by the hospital's governing body? (Authority: T.C.A. § 63-15-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by <u>any</u> hospital in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: T.C.A. § 63-51-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF ACTION
1.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.			

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name_____ **License#**_____
Profession _____

VII. CRIMINAL OFFENSES (See Instructions)

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: T.C.A. § 63-15-105(a)(1))

If "YES" briefly describe the offense(s): YES ❒ NO ❒

	DESCRIPTION OF OFFENSE	DATE	JURISDICTION
1.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒
2.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒
3.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒

VIII. LIABILITY CLAIMS

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? (Authority: T.C.A. §63-51-105(a)(5)) If "YES", indicate the date of claim(s) and the amount of judgment(s), award(s) or settlement(s).

	ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT	AMOUNT
1.		
2.		
3.		

IX. OPTIONAL INFORMATION

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (optional) (Authority: T.C.A. § 63-15-105(a)(11))

	TITLE	PUBLICATION	DATE
1.			
2.			
3.			
4.			

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (optional) (Authority: T.C.A. § 63-15-105(a)(12))

	COMMUNITY SERVICE/AWARD/HONOR	**ORGANIZATION**
1.		
2.		
3.		
4.		

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. § 63-51-113 and/or 63-51-118.

_____ Date:_____
(Signature of Provider)

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